**Danish & O'Laughlin, DDS & Associates**
**400 Bald Hill Road**
**Warwick, RI 02886**
**(401) 738 - 3606**

## Patient Registration

Patient's Name_____ Birthdate_____ Sex: M F
Address_____ Apt#_____ Marital Status: S M D
City_____ State_____ Zip_____
SS#_____ Home Phone (___) _____ Work Phone(___) _____
If you are a full time student what school are you enrolled in._____
Employer's Name
_____ Occupation_____
How did you hear about our practice?_____
Name(s) of any other family member(s) seen in our practice_____

## Person Responsible for this Account

Relationship to Patient { } Self { } Spouse { } Parent/Guardian If self, skip to Insurance Section
Name_____ Birthdate_____ Sex: M F
Does this person & patient reside in the same household? Yes No
Address_____ Apt#_____
City_____ State_____ Zip_____
SS#_____ Home Phone (___) _____ Work Phone(___) _____
Employer's Name
_____ Occupation_____

## Is Patient Covered By Dental Insurance { } Yes { } No

Employee's Name_____ Birthdate_____ Sex: M F
SS# or Subscriber Number (shown on card)_____
Employer's Name _____
Insurance Company_____ Address_____
Relationship to patient: { } Self { } Spouse { } Parent/Guardian Group #_____
Is patient covered by another dental insurance? Yes No

## Secondary Dental Insurance

Employee's Name_____ Birthdate_____ Sex: M F
SS# or Subscriber Number (shown on card)_____
Employer's Name _____
Insurance Company
_____ Address_____
Relationship to patient: { } Self { } Spouse { } Parent/Guardian Group #_____

NOTE: Due to the constantly changing insurance rules and regulations, benefits and deductibles, we are only able to approximate your insurance balance. If your insurance pays more than expected you will be credited the difference. If your insurance company pays less than expected you will be billed the difference. Final responsibility for payment rest with the person responsible for your account.

Date_____ Signature_____
Relationship to Patient_____